

UTAH DEPARTMENT OF HEALTH, PRIOR AUTHORIZATION REQUEST FORM

**ADCIRCA** (tadalafil)

Patient name:\_\_\_\_\_Medicaid or SS#\_\_\_\_\_

Physician Name:\_\_\_\_\_ Contact person:\_\_\_\_\_

Phone#:\_\_\_\_\_Ext. and opt.\_\_\_\_\_Fax#\_\_\_\_\_

Pharmacy\_\_\_\_\_Pharmacy Phone#:\_\_\_\_\_

**All information to be legible, complete and correct or form will be returned**

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**FAX DOCUMENTATION FROM PROGRESS NOTES OR IN LETTER OF  
MEDICAL NECESSITY TO (801) 536-0477**

**CRITERIA:**

- ▶ Minimum age requirement: 18 years old
- ▶ Documented diagnosis of Pulmonary Hypertension

**AUTHORIZATION:**

1 year

**RE-AUTHORIZATION:**

Telephone request from the physician's office or pharmacy.

2/10/10